

Executive Summary

Health Care Financing Administration National Medicare Education Program Coordinating Committee Meeting Westin Fairfax Hotel Washington, D.C.

April 26, 2000

The April meeting of the Health Care Financing Administration's (HCFA) National Medicare Education Program (NMEP) Coordinating Committee was held on Wednesday, April 26, 2000, from 9 a.m. to 1 p.m. at the Westin Fairfax Hotel in Washington, D.C. A list of attendees is provided in Attachment A.

Meeting Topics and Synopsis

Welcome and Introductions^{3/4} ***Carol Cronin***

Ms. Cronin welcomed the Coordinating Committee members, reviewed the agenda, and asked members to introduce themselves. There were several new attendees.

NMEP Update—Carol Cronin

Ms. Cronin provided the participants with an update of recent and upcoming NMEP-related activities:

- Center for Beneficiary Services (CBS) is working with the Department of Health and Human Services and the White House to coordinate a Medicare event tentatively planned for July 24. This event will commemorate the Medicare program's 35th anniversary. Each of the HCFA Regional Offices will be sponsoring events; a satellite network will connect these sites with the Washington, D.C.-based event.
- The April 12 *Federal Register* announced the request for public comment to standardize managed care plan marketing materials including enrollment notices. HCFA welcomes comments on these documents. Also included in this notice was an "Important Message about Medicare Rights: Admission, Discharge, and Appeals." Public comments on these documents are due June 12, 2000. All of these documents are available directly from the NMEP Partners Web site (www.nmep.org).

- The HCFA Employers'-Union Conference was held on March 21-22. Approximately 250 attendees participated in the general sessions and breakouts on topics such as enrollment/disenrollment, supplemental benefits negotiation, and presenting information to beneficiaries. There has been positive feedback both formally through evaluation forms and anecdotally through conversations with attendees. Summaries of several sessions and actual presentations are on the NMEP Partners Website now (www.nmep.gov) The full summary report of the conference will be available on line on the Partners Web site by early summer. HCFA is assessing whether a follow-up meeting is warranted. Ms. Cronin publicly acknowledged Pamela Kalen, with the Employers' Managed Health Care Association, for her efforts in coordinating this conference.
- The next Citizens Advisory Panel on Medicare Education meeting will be at the Phoenix Park Hotel on May 12, 2000, in Washington, DC. The agenda will cover quality issues and will include speakers such as John Eisenberg with the Agency for Healthcare Research and Quality (AHRQ), Dr. Robert Berenson from the Center for Health Plans and Providers (CHPP) at HCFA, and Dr. Jeffrey Kang from the Office of Clinical Standards and Quality (OCSQ) at HCFA. There will also be discussion of how to stimulate public interest in quality measurements.
- The *2000 Guide to Health Insurance* is now available in print format in addition to the online format. Committee members who preordered multiple copies of this document will be receiving them shortly. Anyone who needs additional copies can contact their PDG Account Representative.
- Balanced Budget Refinement Act (BBRA) enrollment and disenrollment changes were discussed as follow-up to Peter Hickman's presentation at the February 28 NMEP Coordinating Committee meeting. Specifically, the issue of when a beneficiary's enrollment in a plan becomes effective was reviewed. If received before the 10th of the month, enrollment is effective the first day of the next month. If received after the 10th of the month, it becomes effective the first day of the second month after it was received. Based on feedback to return the policy to pre-BBRA standards, HCFA explored a commitment to reverse the new policy. This effort was unsuccessful, and HCFA will be moving toward the two-tier system at the end of this month.
- A new publication, *Staying Health at 50+*, developed in collaboration with AHRQ, AARP, and Health Resources and Services Administration (HRSA), is now available. Meeting participants were provided a single copy in their meeting folders. Participants can contact the AHRQ Publications Clearinghouse at (800) 358-9295 or www.ahrq.gov to order additional copies.
- The competitive bidding project on durable medical equipment has extended testing for another year to a new site located in San Antonio, TX. This site is in addition to the original one in Pope County, FL. A press release and Q&A materials were available onsite during this meeting.

- New staff assignments are listed below:
 - Rick McNaney is the Director of Communications for the Center for Beneficiary Services. His responsibilities include promoting and publicizing the four information channels. He was previously with the U.S. Department of Agriculture and the Social Security Administration.
 - Hank Koehler is temporarily overseeing research in the CBS Planning and Analysis Group during Regina McPhillips' extended absence.
 - Tom Kickham is temporarily leading up the Office of Strategic Planning.
 - Janice Flaherty will oversee "REACH": Regional Education about Choices and Health and "SHIPs" State Health Insurance Assistance Program during Mr. Kickham's temporary appointment.

Preview of the Medicare.gov Web Site New Design ^¾ ***Mary Agnes Lauren***

Ms. Lauren provided a brief update on the status of the *Medicare and You 2001* handbook. HCFA has completed consumer testing. Ms. Lauren shared potential cover designs, indicating a strong consumer preference for the design with the flag on it. The flag distinguished the material as a Federal government document versus other marketing materials that beneficiaries receive from various sources.

Next, Ms. Lauren provided an overview of the Medicare.gov (www.medicare.gov) redesign efforts. The new site design is scheduled for launch in May 2000 (live the weekend of May 6). Revisions were based on user feedback, online surveys, and usability testing in a lab. Other facts related to the redesign include:

- The new site will retain the content of the existing site.
- Internet usage is up among beneficiaries from 6.8 percent in 1997 to 21.3 percent in 1999.
- Nursing Home Compare and Medicare Compare continue to be the most popular pages. Nursing Home Compare has received more than 500,000 page views per month. More than 90 percent of users felt both of these pages were easy to use and helpful.
- The breakdown of Web site users is 52 percent beneficiaries or family members and 33 percent health providers.

The following changes will be made to the Medicare.gov design:

- How to find a health plan (users were unaware of Medicare Compare).
- Minimize the graphics because of the delay in downloading the flag on the home page.
- Simplify the language.

The primary goal of the new design effort was to enhance usability, navigation, content, system performance and customer service while still preserving the identity, recognition, and wide variety of content available on the current site. This goal will be achieved by completing the following:

- Designing a home page that features the new American flag logo, which helps maintain recognition as an authoritative and reliable source of information
- Applying a new template across the site to improve consistency, navigation capability, and readability.
- Including disenrollment rates for managed care plans and staffing data for nursing homes.
- Improving databases by increasing performance (speed).

A publicity and promotional strategy will maximize the use of a wide range of media channels including press releases, interviews, and demonstrations.

Provider Outreach^{3/4} Barbara Paul, M.D.

Dr. Paul provided a summary of her experience as a practicing physician and with organized medicine before joining HCFA as a Medical Advisor in 1999. She works with both CBS and CHPP and is currently directing the activities and findings of the Physicians' Regulatory Issues Team (PRIT).

This team was formed to respond to physicians' complaints about regulatory burden. It started its efforts by examining the often alleged "133,000 pages of HCFA regulation." It found that this allegation was not accurate and that burden is more than sheer volume. Feedback from physicians revealed the following findings:

- The burdens faced by physicians are enormous.
- HCFA does contribute to excess burden.
- Burdens can be barriers to quality health care for beneficiaries.

The sources of burden are divided into three categories—rule volume, complexity/obscurity, and risk. The team has initiated activities in response to this three-part framework, with a focus on complexity/obscurity issues. Examples of issues related to risk that the PRIT is working on, include coding guidelines and fraud and abuse efforts. Efforts on volume reduction are under way but are currently very early and developmental. Current outreach activities to reduce complexity/obscurity problems include the following:

- A monthly conference-call series with physician organizations.
- A HCFA exhibit series with staffed information booths at professional organization annual meetings.
- Regional Office and Central Office joint efforts.

Current Medicare carrier activities include the following:

- Restoring carriers' toll-free inquiry lines per physicians' requests
- Enhancing carrier Web sites and electronic bulletin boards for physicians
- Providing focused education for physicians who make frequent errors because of confusion or obscurity to our rules for billing.

Dr. Paul indicated that she intends to review the HCFA Web site, www.hcfa.gov, from a physician perspective to determine how it can be enhanced for this user population. The *Medicare and You 2001* handbook will be distributed to physicians nationwide this fall. Furthermore, national articles will be available for physicians on Medicare issues.

Discussion

Following Dr. Paul's presentation, the following topics and feedback were addressed in a round table discussion:

- Carriers need to be more proactive in their efforts to inform physicians about medical review policies.
- Carrier inconsistency in approving or denying coverage for the same unit of service for the same patient is disconcerting and should be reviewed.
- Carriers who require notarized authorization from beneficiaries are adding to the burden.
- HCFA needs to investigate the burdens that are causing upcoding and exaggerated claims. Survey data on this issue were reported in a recent issue of JAMA.
- An issue was raised and discussed regarding Indian Health Services and Tribal Communities.
- It needs to be clarified whether physicians are downcoding before submitting claims or only after being audited. The majority of Medicare claims are paid automatically without any human scrutiny.
- Fraud and abuse efforts may have a negative effect on care. Some physicians may refuse to provide care to avoid coding errors. This undermines doctor-patient relations by weakening trust. It is advisable to pursue fraudulent providers, but HCFA should recognize the undesirable consequences of these efforts.
- The relationship between a bilingual health care provider and a non-English speaking patient is critical. Physicians could be used as mechanisms for targeted outreach to minority and underserved populations. HCFA needs to partner with organizations that represent these populations to develop applicable programs.
- There was a recommendation for HCFA to use local physician networks.
- It is difficult to locate physician materials on the HCFA Web site (www.hcfa.gov).

Plan Benefit Package¾ Christine Perenich

Ms. Perenich provided Committee members with a summary of the Plan Benefit Package (PBP), which breaks benefits into four categories:

- Medicare Covered (basic fee-for-service)
- Additional Benefits (e.g., paid from excess payment from HCFA)
- Mandatory Supplemental Benefits (must take, such as prescription drugs or vision)
- Optional Supplemental Benefits (option to choose or decline benefits, such as prescription drug coverage).

PBP is a new standardized, data-driven tool for contract year 2001 that will help managed care organizations fully describe their plan benefit package. The data-driven feature provides the capacity to compare and contrast plans. The following provide an overview of PBP. It was:

- Developed to standardize benefit packages
- Submitted electronically with Adjusted Community Rate (ACR); ACR due by July 1
- Used to assist in reviewing and approving benefit packages.

Additional uses for PBP include the following:

- Marketing review and approval
- Refining the *Medicare & You* Handbook
- Generating Medicare Compare data
- Developing Regional Office (RO) summaries of benefits.

The primary sections of PBP relate to management (considered home base), organization (Section A); benefits (Section B); access and dual eligibility (Section C); and premium, Point of Service (POS), and optional supplemental benefits (Section D). Section C, which deals with dual eligibility and access, contains open-ended questions. Using responses from this year, this section will be refined to become more data-driven and close-ended.

Discussion

Following Ms. Perenich's presentation on PBP, the following topics were addressed:

- Point of clarification—PBP is a tool to standardize the *descriptions* of benefits packages.
- PBP will not necessarily speed up the ACR approval rate.

- Services that overcome access problems due to language barriers, that is, translation services, should be included in these benefits package descriptions. PBP is a living tool; therefore, HCFA welcomes comments and suggestions to help shape the tool for the next contract year.
- The number of providers on each plan is not provided on PBP but could be addressed in the open-ended Section C to recommend this information be provided next year.
- Is this the same tool each year? Ms. Perenich responded no, that this tool changes and evolves with the Medicare program. Partners can contact Ms. Perenich if they are interested in submitting questions to add to the PBP (although the PBP is subject to the Paperwork Reduction Act clearance and therefore is reviewed by the Office of Management and Budget (OMB) clearance).

Ms. Perenich can be reached at (410) 786-2987 or cperenich@hcfa.gov for response to further questions or comments.

Private Fee-For-Service Plan Overview¾ Paul Olenick and Bob Adams

Mr. Olenick began by providing an overview of the Private Fee-For-Service (PFFS) Plan:

- A PFFS plan is a Medicare + Choice (M+C) plan offered by a private insurance organization that pays providers on a fee-for-service basis. Therefore, M+C PFFS plans must meet the same regulatory requirements as other M+C plans types with limited exceptions.
- Enrollees can obtain services from any licensed provider in the United States who is qualified to be paid by Medicare and accepts the plan's terms of payment. Enrollees in a M+C PFFS plan are entitled to the same coverage of Part A and B services as enrollees in M+C coordinated care plans.
- The M+C program guidance is contained at 42 CFR Part 422.
- HCFA pays M+C PFFS plans based on capitation payment for each Medicare enrollee.
- Enrollees have the same appeal and grievance rights as enrollees in other M+C plan types. The appeal process is different from Original Medicare.
- To enroll, beneficiaries must reside in the service area of the PFFS plan.

The defining elements of a PFFS plan are:

- Fee-for-service payment is made to providers.
- Enrollees cannot be restricted to a network.
- Payment of providers is uniform.

M+C access requirements (PFFS must meet at least one of the following) include:

- Established payment rates for providers that are not less than the rates that apply under Original Medicare
- Established (signed) contracts with a sufficient number and range of providers to furnish services covered under the plan

- A combination of 1 and 2.

Mr. Olenick discussed deemed providers as follows:

- Deemed providers must accept the plan's terms of payment in lieu of a signed contract with the PFFS plan.
- To be deemed, before furnishing services the provider must be informed of enrollment in a PFFS plan and possess or have reasonable access to the plan's terms of payment.
- This is different from other M+C plans because only a deemed contract, not a signed contract, is necessary.
- Providers who have furnished services to a PFFS enrollee but who have not met the requirements to be considered a deemed provider are noncontract providers. As an example, this status may result in emergency situations where establishing deemed-provider status is not possible before providing an enrollee care.

The reasons beneficiaries might join a PFFS plan include:

- More provider choice because there is no restriction.
- The plan may be less expensive than Original Medicare with a Medigap policy. Medigap cannot be used with a PFFS plan because it is a M+C plan.
- The plan may be attractive in rural areas where there are fewer health care choices.

Mr. Adams next discussed the PFFS education rollout. The purpose of the rollout is to provide an overall understanding of the PFFS option and information sources to help explain it to beneficiaries and their caregivers.

The objectives of the education rollout are to ensure that potential enrollees:

- Receive accurate and reliable information
- Can access information
- Understand options
- Are aware of where to go for help.

The materials to be used in the education rollout include:

- PFFS booklet, *Your Guide to Private Fee-for-Service Plans*
- Q&A list for partners
- Plan-specific information on **www.medicare.gov**
- Additional information and training for ROs, SHIPs, and REACH campaign participants and other partners.

Information channels that are available to support the education rollout include the Medicare Choices Helpline (1-800-MEDICARE), **www.medicare.gov**, SHIPs, and REACH train-the-trainer sessions. A “welcome packet” will be developed and distributed to beneficiaries to share with their health care providers.

HCFA will inform providers through the following activities:

- Provide basic information to physicians and other providers, medical associations, and professional associations
- Post Q&As and “best practices” on the HCFA Web site (**www.hcfa.gov**)
- Include information in carrier and intermediary bulletins.

Plans will be able to inform providers through the following activities:

- Distribute a press release
- Provide a toll-free line and Web site
- Encourage enrollees to share PFFS-plan “welcome packets” with providers.

Discussion

Following the PFFS presentations, the following issues were raised:

- Why is there a requirement for a beneficiary to be in a service area?
- Other aspects of M+C plan apply to PFFS.
- Language in the PFFS guide is misleading (see bottom of page 8 referencing the charge for additional coinsurance or copayment amounts by doctors/hospital).
- Potential benefits of this plan are that it makes more options available (broadens providers available), especially necessary because of language barriers or plans withdrawing.
- There is concern about what providers can accept in terms of payments and copayments.
- Will there be more PFFS plans available in the near future? HCFA is not aware of any new plans on the horizon.

Experts on beneficiary liability were not present at this meeting. HCFA will conduct a training session to continue the discussion of this issue and will include these experts.

Medicare & You Assessment Results¾ Liz Goldstein

Dr. Goldstein provided an overview of the performance assessment systems for each of the four information channels: print materials, toll-free line, Internet, and REACH.

Medicare and You Handbook

Assessment activities for the *Medicare and You* handbook, which included surveys, focus groups, and postcards, show that beneficiaries and caregivers are generally satisfied with the document. Assessment data indicate the following:

- Lower usage is correlated with persons having only a high school education, being in poor health, having poor knowledge of the Medicare program, not having changed or reviewed insurance during the year, and not having noticed publicity of Medicare changes.
- Most beneficiaries realize that the handbook is a Government publication.
- Most beneficiaries find the handbook “fairly easy” to understand, with the FY 2000 handbook easier for less-educated beneficiaries to read than previous editions.
- The Quality Section often went unnoticed or caused confusion for many beneficiaries.

Selected improvements to the handbook include the following:

- Adding color tabs for local information pages
- Clarifying the quality information pages
- Changing the CAHPS measure in the quality section.

Medicare Choices Helpline (1-800-MEDICARE)

To assess the toll-free line, HCFA conducted mystery shopping and a callback survey. The survey indicates that 83 percent of callers are satisfied or very satisfied with their experience with 1-800-MEDICARE. Results from mystery shopping, which uses a confederate to act as a beneficiary or family member, are also positive. To improve the toll-free line, HCFA has implemented the following:

- Simplify the desktop application used by the customer service representatives
- Simplify the automated response unit
- Retrain customer service representatives
- Conduct more intensive monitoring.

Internet (www.Medicare.gov)

The Medicare Web site, www.medicare.gov, assessment activities included the review of bounceback forms, computer labs sessions, focus groups, and expert review of the site.

Beneficiary access to the Internet has increased. In 1997 6.8 percent of Medicare beneficiaries accessed the Internet, and by 1999 that percentage increased to 19.5.

REACH

Because of time limitations, Ms. Goldstein deferred the information on REACH activities to the enclosed handout included in the meeting background materials.

Case Studies

Case studies included interviews and site visits, surveys of beneficiaries, and three rounds of focus groups. The sites involved with the case studies include Sarasota, Florida, Dayton, Ohio, Tucson, Arizona, Springfield, Massachusetts, Eugene, Oregon, and Olympia, Washington. Data from these sites have provided HCFA with information on the current status of managed care in local markets.

Overall, the persons more knowledgeable about Medicare are the highest users of the four information channels. The frequency of seeking information is positively related to being married, having more than a high school education, having reviewed or planning to review insurance coverage, and having had a change in insurance coverage in the last year.

NMEP Planning has taken place at the state rather than the local level.

HCFA's future plans for assessment include the following activities:

- Continue to assess each of the information channels.
- Continue to document the *Medicare & You* education program at the case study sites.
- Conduct interviews and focus groups with Alliance Network partners to obtain feedback. All partners will be invited to participate in follow-up focus groups.

While there are some implications that beneficiary understanding has begun to increase, overall, there is still a lack of basic understanding of the Medicare program.

Discussion

Following Dr. Goldstein's presentation, the following topics were discussed:

- Were the selected sites diversified for minority outreach?
- More extensive work needs to be done to improve outreach strategies for minority populations. The REACH campaign strives to identify groups with barriers and then works to overcome these barriers.
- HCFA recognizes the need to understand special populations. HCFA's ROs and the HORIZONS Project are working to understand differences in reaching out to different cultural groups.

- Focused outreach should target the 20 percent of beneficiaries contacted during the case study that claim to know nothing about Medicare rather than conducting widespread efforts that continuously reach more knowledgeable information seekers.
- Alliance partners want their role clarified and to share their experiences.
- Efforts will be conducted to assess whether partnerships are working.

For additional information or comment, Dr. Goldstein can be reached at (410) 786-6665.

Open Discussion of Partner Activities¾ All Participants

- Ellen Tunstall, Office of Personnel Management (OPM), mentioned that HCFA and OPM are developing short, concise messages on patient safety as an outcome of the Institute of Medicine report.
- Mimi Lising, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) discussed the National Diabetes Education Program (NDEP), collaboration between NIDDK, HCFA, and the Centers for Disease Control and Prevention (CDC) titled “Control Diabetes for Life.” This campaign includes tailored materials for minorities and seniors/Medicare beneficiaries. Ms. Lising offered to give a presentation at the next meeting and encouraged participants to get involved if they are interested in diabetes.
- Clayton Fong, National Asian Pacific Center on Aging, suggested that HCFA look at dissemination efforts and documents that have been popular and use the information to conduct more focused outreach. NMEP strategy works well for the general population. This strategy can be modified by subgroups and used in a coordinated manner.

Suggested Topics for Next Meetings¾ All Participants

The next meeting is scheduled for Wednesday, July 26, 2000. Topics which were suggested for discussion include:

- Health promotion activities for diabetes, specifically the NDEP campaign
- HCFA’s long-term care education campaign
- Status on health plans for the next contract year (Ms. Cronin stated that HCFA would coordinate something on this topic before the next meeting if necessary.)
- Ms. Baca offered to give a presentation at a future meeting (October 25) on the National Indian Council on Aging.

**National Medicare Education Program
Coordinating Committee Meeting
Westin Fairfax Hotel
Washington, DC
April 26, 2000**

Appendix A: List of Attendees

AARP

Ms. Jennifer Leach
Ms. Nileeni Meegama

AFL-CIO

Ms. Marilyn Park

Alzheimer's Association

Ms. Katie Maslow

American Association of Health Plans

Ms. Candace Schaller

American Bar Association

Ms. Leslie Fried
Ms. Erica Wood

American Medical Association

Ms. Sharon McIlrath

**American Medical Rehabilitation
Provider's Association**

Ms. Patricia Wenz

Bell Atlantic Network Services

Ms. Sheila Meehan

Blue Cross Blue Shield Association

Ms. Jane Galvin

Center for Medicare Advocacy

Ms. Vicki Gottlich

Center for Medicare Education

Ms. Susan Reinhard
Ms. Marisa Scala

Citizen Advocacy Center

Ms. Rebecca LeBuhn

U.S. Department of Labor

Ms. Deborah Milne

eBenX

Ms. Allison Johnson

EDS

Ms. Lola Jordan

**Employers' Managed Health Care
Association**

Ms. Lisa Corcoran

Health Insurance Association of America

Ms. Marianne Miller
Ms. Kathleen Fyffe

Hewitt Associates, LLC

Mr. Frank McArdle

**Joint Commission on Accreditation of Health
Care Organizations**

Mr. Anthony Tirone

Medicare Rights Center

Mr. Steve Edelstein

**National Institute of Diabetes and Digestive
and Kidney Diseases**

Ms. Mimi Lising

National Academy on an Aging Society

Ms. Kristen Kilker

National Asian Pacific Center on Aging

Mr. Clayton Fong

**National Association of Area
Agencies on Aging**

Ms. Adrienne Dern

National Association of Health Underwriters

Ms. Nancy Trenti

**National Association of Insurance
Commissioners**

Ms. Alethia Jackson

National Association of State Units on Aging

Ms. Kathy Konka

National Council on the Aging

Mr. Howard Bedlin

National Indian Council on Aging

Ms. Rebecca Baca

National Senior Citizens Law Center

Ms. Kim Glaun

Office of Personnel Management

Ms. Ellen Tunstall

Older Women's League

Dr. Sarah Gotbaum

Plymouth State College

Dr. Stephen Gorin

Public Service Enterprise Group

Ms. Kathy Kostecki

**State Health Insurance and Assistance
Programs**

Ms. Elizabeth Curtis

Towers Perrin

Mr. Sri Palanisamy

UltraLink

Mr. Howard Matsukane

Visiting Nurse Associations of America

Ms. Pamela Sawyer

William M. Mercer, Inc.

Mr. Chip Kerby

Watson Wyatt

Mr. Richard Bruns

Mr. Mark White

Invited Guests

Aspen Systems

Ms. Leonore Burts

Consultants for Corporate Benefits, Inc.

Mr. Grady Ford

Ms. Deborah Weber

IQ Solutions

Ms. Dina Boyd

Ms. Kimberly Dawkins

Ms. Meredith Mastal

Ms. Cherie Mitchell

Ms. Jennifer Noyes

Health Care Financing Administration

◆ Mr. Joe Adams

◆ Mr. Peter Ashkenaz

◆ Ms. Carol Cronin

◆ Ms. Lorna Evans

◆ Ms. Preeya Gholkar

◆ Dr. Liz Goldstein

◆ Ms. Lis Handley

◆ Ms. Valerie Hartz

◆ Ms. Dianne Houghton

◆ Ms. Mary Agnes Laureno

◆ Ms. Michael McMullan

◆ Mr. Rick McNaney

◆ Mr. Steven Newman

◆ Mr. Paul Olenick

◆ Dr. Barbara Paul

◆ Ms. Christine Perenich

◆ Mr. Spencer Schron